Accountable Care Organizations and Status of Exchange Implementation

Presentation to

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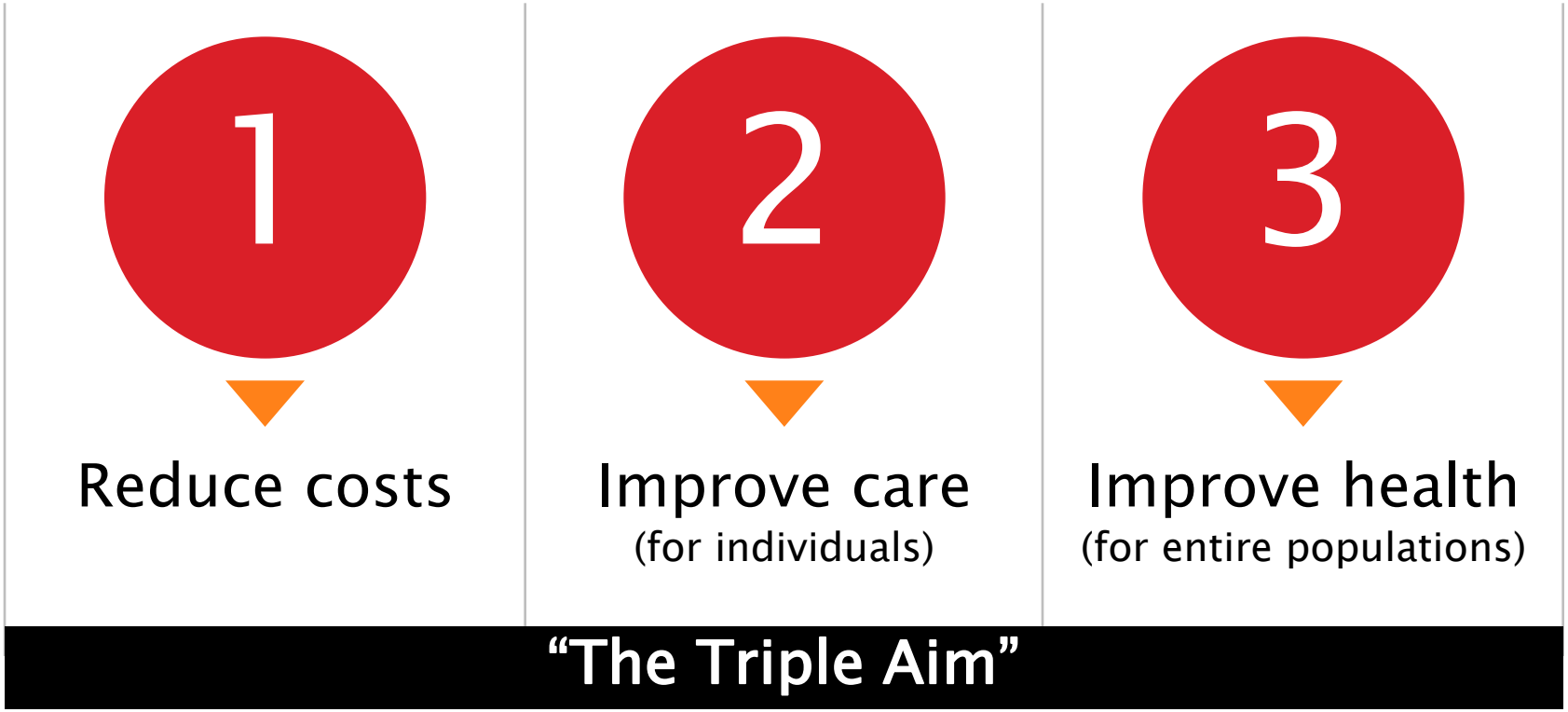
Goals of Health Care Reform



In order to achieve those goals, two things are necessary: payment reform and delivery system reform

Key provisions of the Patient Protection and Affordable Care Act (PPACA)

Expanded Coverage
- Medicaid
- Tax credits and subsidies
- Employer and individual mandates

Insurance Reforms
- Exchanges
- MLR/Premium requirements
- High-risk pools

Payment Reforms
- Cuts
- Reduced Medicare Advantage subsidies
- Bundling, global payments
- Accountable Care Organizations (ACOs)

Workforce Enhancements
- Primary care physicians (PCPs)
- Advanced practice nurses and physician extenders

Quality Improvements
- Reduced payment for Hospital Acquired Conditions (HACs) and preventable readmissions
- Core measures
- Patient satisfaction

ACOs – the new face of health care integration

Doctors **ACO** Hospitals

What is an ACO?

- Physicians (PCPs and Specialists) and hospital(s) working together to coordinate care and held accountable for the cost and quality of care delivered to a defined set of individuals
- Care is managed across the continuum of inpatient and ambulatory settings

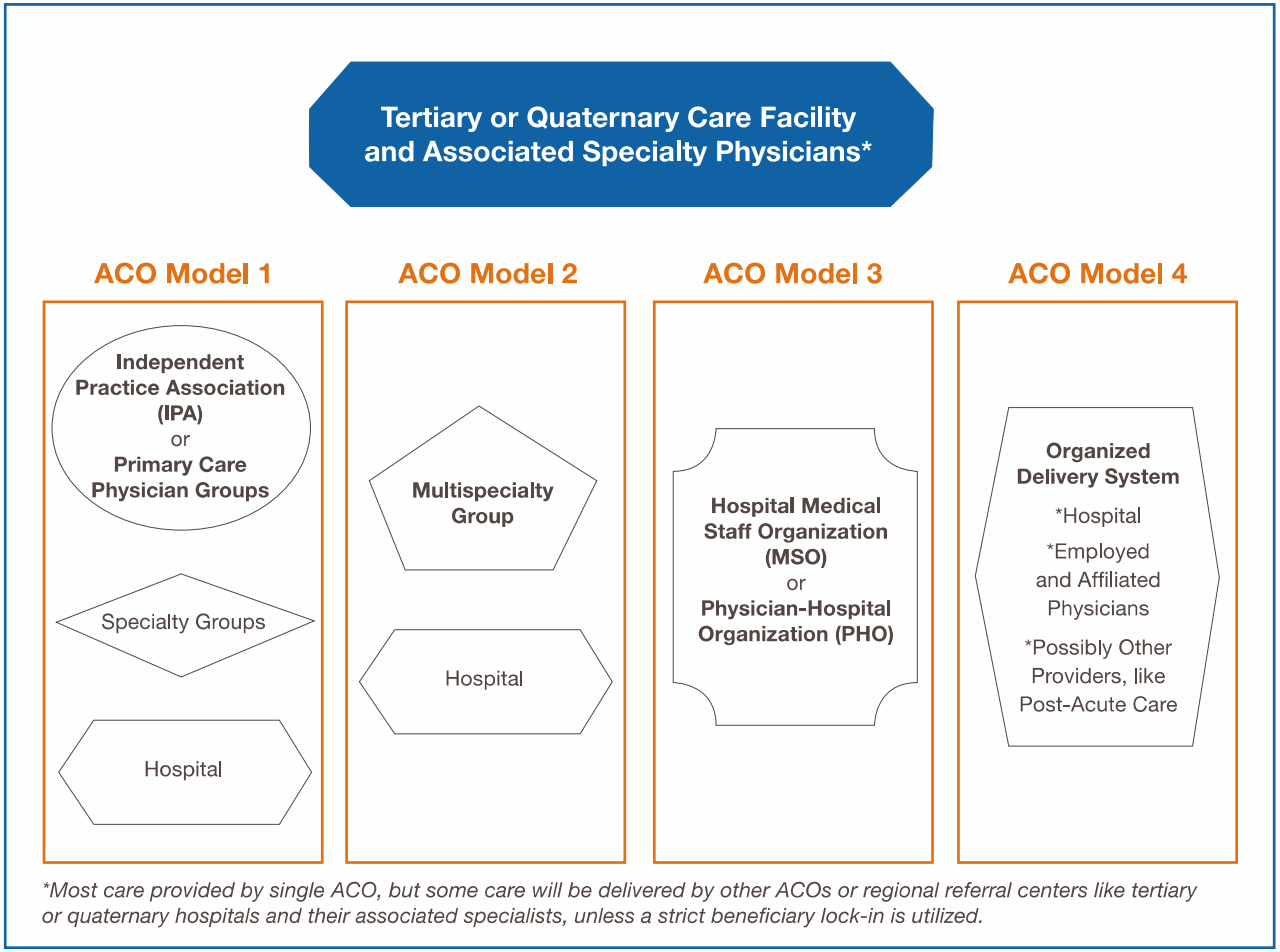
What is the purpose of an ACO?

- Provide integrated care to improve outcomes and reduce cost
- Provide a counter-balance to the fee-for-service system that incents volume of services rather than value of services

How is this different from an HMO?

- Accountability is focused directly on providers and the delivery systems instead of health plans
- CMS will contract directly with providers without the health plan as an intermediary

Different ACO configurations may take shape



Source: Devers, K and Berenson, R: "Can Accountable Care Organization Improve the Value of Health Care by Solving the Cost and Qualty Quandries?". Robert Wood Johnson Foundation: October 2009.

Legislative requirements to become a ACO

The law provides the structure for ACOs –

ACO Operational Requirements

- Have a formal legal structure to receive and distribute shared savings
- Have a sufficient number of primary care professionals for the number of assigned beneficiaries
- Agree to participate in the program for not less than a 3-year period
- Have sufficient information regarding participating ACO health care professionals as HHS determines necessary to support beneficiary assignment and for the determination of payments for shared savings
- Have a leadership and management structure that includes clinical and administrative systems
- Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR)), and (c) coordinate care
- Demonstrate it meets patient-centeredness criteria, as determined by HHS

The ACO concept is not just for Medicare

- The ACO concept has been widely discussed among health researchers and pundits for years
- It is widely believed that well-conceived ACOs can achieve both cost and quality improvements because the coordinated and collaborative nature of the delivery system itself is paid for and rewarded for its quality outcomes, not for its volume of services
- Experts believe that ACOs must be physician-led, primary care-centered, and patient-focused systems of care
- The government focus on ACOs is within the context of Medicare, but the concept applies to all patients covered by all forms of insurance
- ACO development has extended far beyond the CMS model for Medicare patients – many private insurers have embraced the concept and are rapidly advancing similar models

What is the difference between a medical home and an ACO?

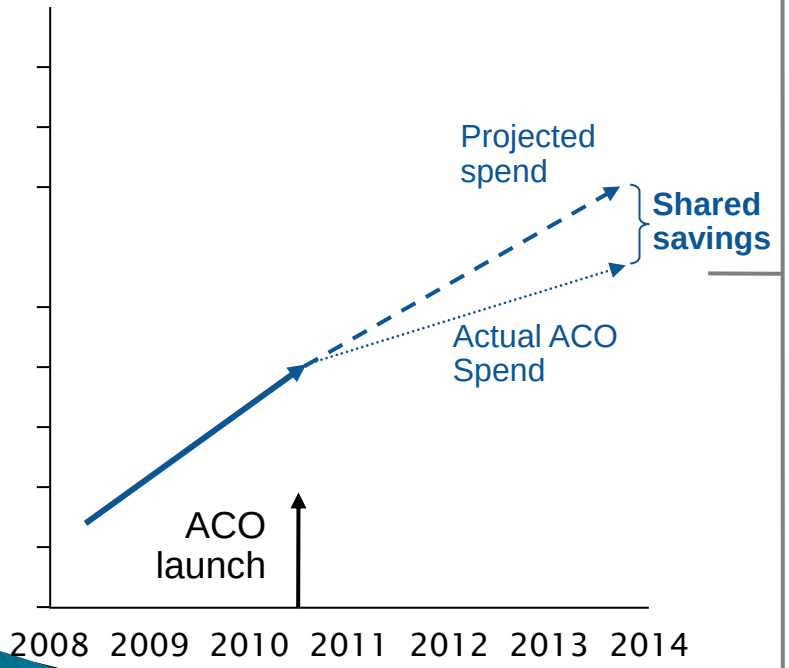
- The Patient-Centered Medical Home model was proposed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association in 2007.
  - An enhanced primary care delivery model that strives to achieve better access, coordination of care, prevention, quality, and safety within the primary care practice, and to create a strong partnership between the patient and primary care physician
  - Like accountable care organizations, the medical home model is referenced many times in the Affordable Care Act as one way to improve health outcomes through care coordination
- The Accountable Care Organization is also based around a strong primary care core, but ACOs are comprised of many "medical homes" – in other words, many primary care providers and/or practices that work together
- ACOs are accountable for the cost and quality of care both within and outside of the primary care relationship
  - Must include specialists and hospitals in order to be able to control costs and improve health outcomes across the entire care continuum
  - Able to better manage the care for a greater population of people with a larger budget

How will ACOs generate a return on investment?

ACOs will continue under the FFS payment system, and Medicare will provide shared savings to ACOs that meet a quality performance threshold AND achieve a minimum savings rate (MSR) above a benchmark amount.

Shared Savings Program

(illustration only)



CMS proposes two alternatives for rewarding quality…

Option 1: Performance Scoring

- CMS would use quality performance standards to calculate a total performance score for an ACO
- The performance score would determine an ACO's shared savings percentage

Option 2: Minimum Quality Threshold

- If an ACO meets the threshold for quality measures and benchmarks, it would be eligible for a percentage of shared savings attributable to quality
- If an ACO fails to meet the thresholds, it would not be eligible for savings

Achieving quality + MSR thresholds generate shared savings payment

One-sided risk

Two-sided risk

Critical success factors and challenges

Critical Success Factors

- The ability to incent hospitals, physicians, and other providers to form linkages that facilitate coordination of care delivery throughout different settings
- The collection and analysis of data on costs and outcomes (Nelson, 2009)
- The role of ACOs in integrating and aligning provider incentives in care delivery requires certain key competencies:
  - Leadership
  - Organizational culture of teamwork
  - Relationships with other providers
  - IT infrastructure for population management and care coordination
  - Infrastructure for monitoring, managing, and reporting quality
  - Ability to *assess* and manage financial risk
  - Ability to receive and distribute payments or savings
  - Resources for patient education and support

Challenges

- Creating innovative models to align physician compensation with the changing health care focus
- Decreasing fragmentation in the system
- Collecting, analyzing and leveraging data to reduce readmissions, increase quality, etc.
- Increasing access to primary care physicians and enabling PCP coordination of care across the ACO
- Changing the care focus from the treatment of the sick to the management of total population health
- Designing systems to support new risk management, reporting and payment requirements
- Developing clinician policies and protocols and ensuring adherence
- Balancing patient choice/freedom with needs for provider to be able to control care

Source: 2010 AHA Research Synthesis Report

Recent headlines in mergers and acquisitions

New Forces Driving Rise in Not-for-profit Hospital Consolidation

Hospital Groups Will Get Bigger; Unlikely Partnerships Could Emerge

Hospital Mergers May Enhance Debt Ratings by Reducing Risk

"Health care reform and an unsustainable payment system have driven not-for-profit hospitals to look for partnerships. They are choosing to consolidate with other health care systems to boost their market presence and strengthen balance sheets"

"Consolidation offers the promise of greater operating efficiency and risk diversification across larger organizations, likely leading to stronger and more stable bond ratings"

Significant pension liabilities for hospitals with defined benefit plans is a new issue in consolidation discussions

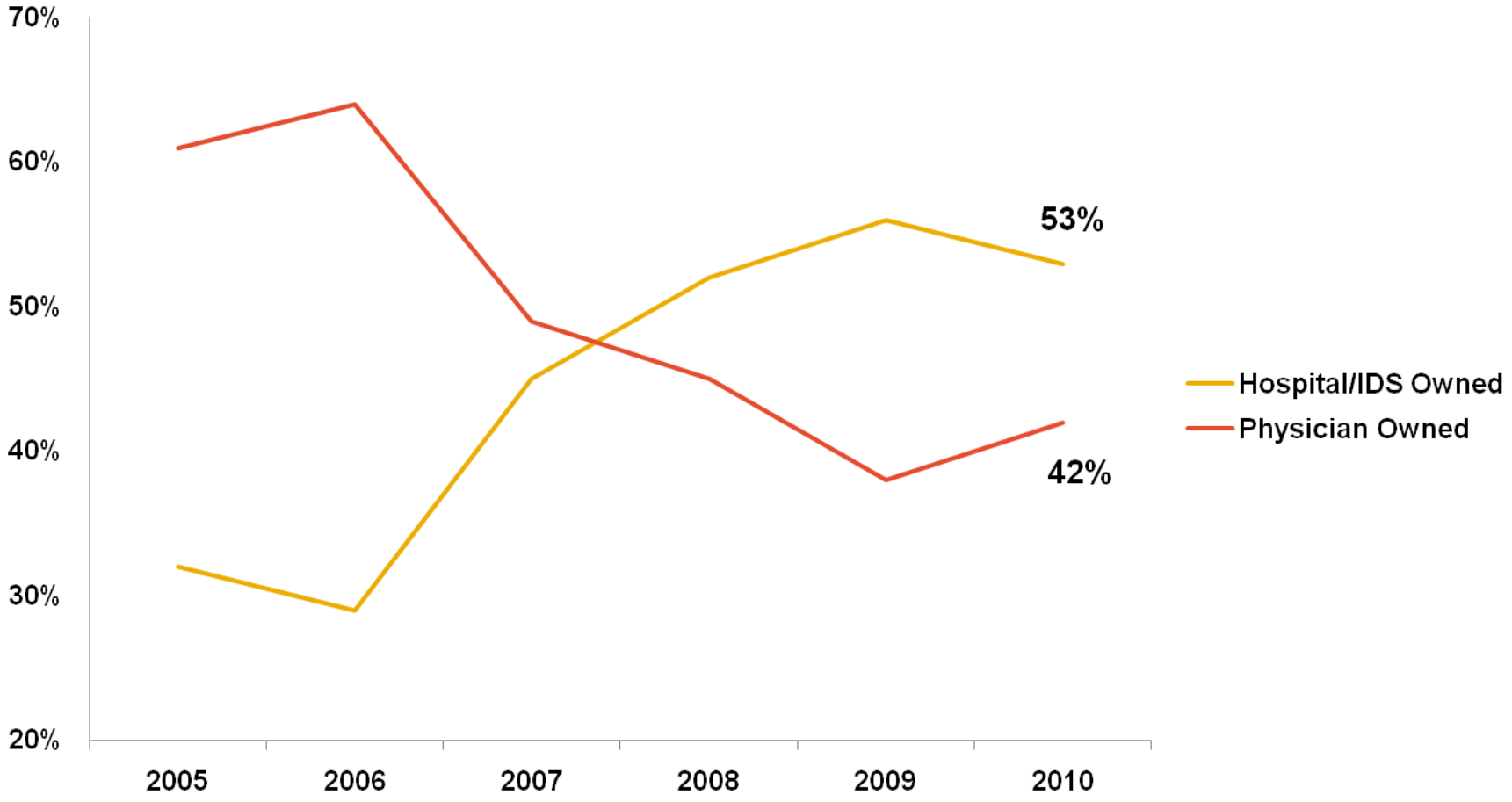
- insurers, hospitals and other large healthcare companies are buying up physician practices in order to better position themselves for changes in how the federal government and other payers will reimburse for medical care
- UnitedHealth Group Inc., the nation's largest health insurer, has acquired several medical groups through a subsidiary
- McKesson, Inc. recently acquired US Oncology Network.
- DaVita Inc., a leading provider of kidney care in the United States, recently acquired Torrance-based HealthCare Partners, the largest operator of medical groups in the U.S.

Deal types

- For-profits buying not-for-profits
- Not-for-profits creating for-profit subsidiaries and buying not-for-profits
- Catholic hospitals merging with Jewish hospitals
- Catholic hospitals selling to for-profits
- Financial buyers acquiring not-for-profits and converting to for-profits
- Insurance companies buying hospitals
- **Everyone buying doctors…**

U.S. Physician Practice Ownership

Hospital/IDS Owned increased to 53% in 2010 from 21% in 2000; latest statistics show Hospital ownership f physician practices has increased to 32% since 2010



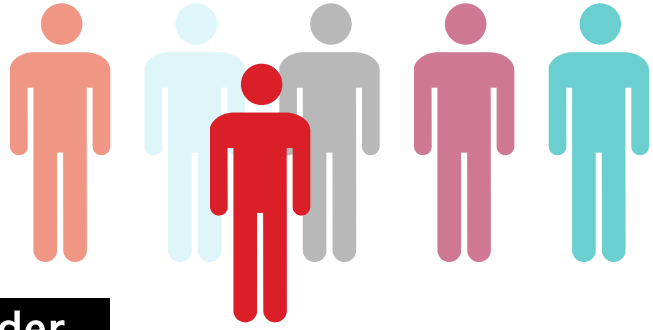
Source: MGMA Cost Survey, 2006-2011

Cultural Challenges in Delivery System Transformation

- Independent
- Reactive
- Autonomy
- Cost-based fees
- Individual physician view
  - "What I do…"

For whatever patients happen to show up
While the patient is in front of me

Must also consider how additional revenue – and potential losses – from risk-sharing programs will be allocated



- Owned
- Accountable
- Standardization
- Fee-based pay
- Organized process view
  - "What the organization does…"

For a defined population of patients
Using organized care management processes

What is an Exchange?

- Organized and competitive marketplace
- Information to Consumers
- Serve individuals and small businesses

- Current examples:
  - State run- Massachusetts Connector and Utah Health Exchange
  - Private Multi Carrier- CBIA, HealthPass of NY, AON, Extend Health and California Choice
  - Private Single Carrier- Bloom, Highmark and Towers Watson

Timeline

November 16, 2012

States submit blueprint application

October 1, 2013

Open Enrollment

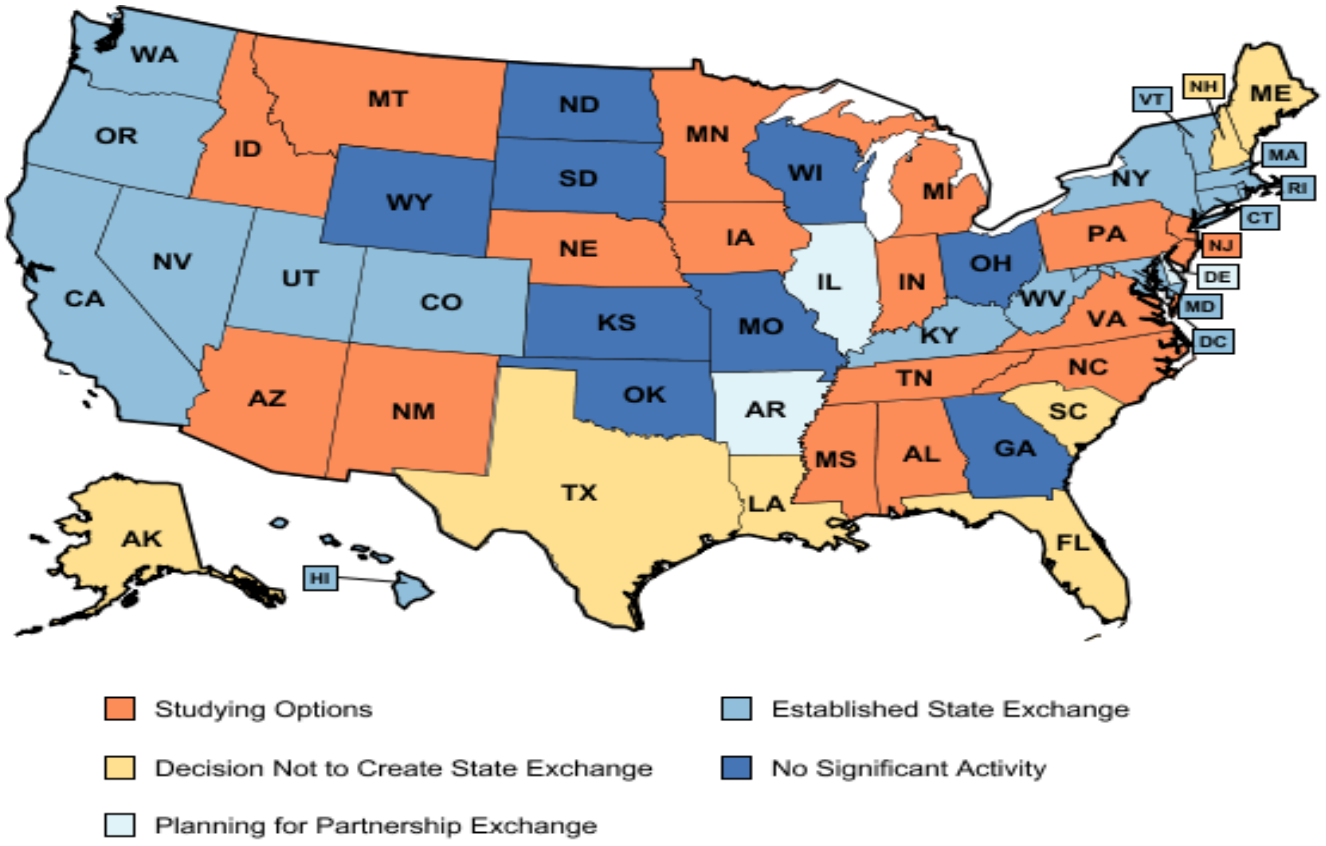
January 1, 2014

Coverage Begins

ISSUES

- State vs. Federal
- Governance
- Role in Marketplace
- Role of Existing Market Regulator
- Integration of Medicaid
- Distribution Channel
- Costs and Sustainability
- Products Sold

Status of State Implementation



State Action Toward Creating Health Insurance Exchanges, as of September 14, 2012: Status of State Action

THE HENRY J. KAISER FAMILY FOUNDATION statehealthfacts.org
Your source for state health data

State-Based Exchange	• State operates all exchange activities; however, state may use federal government services for the following activities: Premium tax credit and cost sharing reduction, Exemptions, Risk adjustment program and Reinsurance program
State Partnership Exchange	• State operates activities for Plan Management, Consumer Assistance or Both
Federally Facilitated Exchange	• HHS operates; however, state may elect to perform or can use federal government services for the following activities: Reinsurance program and Medicaid and CHIP eligibility, assessment or determination

Challenges

- Time
- Money
- Expertise
- Other Market Changes
- Relationship to Cost

Value Proposition

- Consumer Engagement
- Competition
- Portability
- Administrative Efficiency
- Seamless Marketplace